STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155005	A. BUILDING 00 B. WING	06/22/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES	1345 N MADISON AVE ANDERSON, IN46011

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F0000	This visit was for the Investigation of Complaints numbers IN00091581, IN00091201, and IN00092285. Complaint IN00091581 - Unsubstantiated due to lack of evidence. Complaint IN00091201 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309. Complaint IN00092285 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates : 6/20, 6/21, and 6/22, 2011 Facility number : 000005 Provider number : 155005 AIM number : 100270840 Survey team: Kim Davis, RN Census bed type : SNF : 24 SNF\NF : 127 Total : 151 Census payor type : Medicare : 24	F0000	July 8, 2011 Long Term Care Division, 4th Floor2 North Meridian StreetIndianapolis, IN 46204 RE: ManorCare Health Services of Anderson 1345 N. Madison Ave. Anderson, IN 46011 Dear Kim Rhoades: Enclosed is our Plan of Correction and credible allegation of compliance for our complaint survey completed on June 22, 2011. If you should have any other questions or need additional information, please contact me at the above address or phone numbers. You may also contact me via email at 421admin@hcr-manorcare.com. Sincerely, Nicole Fields, HFAAdministrator	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicaid : 90 Other : 37 Total : 151 Sample : 8 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 6/23/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to ensure the physician's orders were followed for medication administration for 1 of 4 residents reviewed for medication administration in a sample of 9 (resident # B). Findings include: On 6/20/11 at 7:55 a.m., Resident # B was overheard speaking with LPN # 1. The resident indicated he had found two of the pills that were spilled earlier during the medication administration on the floor and took them. The resident indicated he	F0282	**F 282 :D** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Incident report completed. Resident B was evaluated on 6/21/11 for any negative effects from taking unknown medication/pills found on the floor. No negative effects noted. Physician was notified of incident and no new orders obtained. Family was notified of the incident. Resident B was educated regarding incident and instructed not to take any pills found on the floor and to	07/15/2011

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	took a little white pill and a football shaped, red, liquid filled pill. The nurse told the resident she would have given him clean pills to take. LPN # 1 was interviewed on 6/20/11 at 11:00 a.m. The nurse indicated she had taken the morning pills to Resident # A earlier in the morning. She indicated as he was taking the pills, some fell onto his chest. The resident picked pills off his chest and swallowed them. The nurse indicated she had not looked around on the bed or the floor for any other pills. The clinical record of Resident # B was reviewed on 6/21/11 at 8:30 a.m. The record indicated the resident's diagnoses included, but were not limited to, heart disease, gastroenteritis, and kidney disease. The nurses notes from May 20, 2011 through June 19, 2011 all indicated the resident was alert and orientated. There were no nursing notes for June 20, 2011. There were no notes to mention the medications found by the resident on the floor on 6/20/11. The June 2011 Medication Administration Record (MAR) was reviewed. The MAR indicated the resident's 8 a.m. medications		notify the Nurse. LPN #1 involved received 1:1 education regarding medication administration and timely reporting of an incident. The ADNS or designee will complete two random medication passes with LPN #1. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** Residents that receive medications have the potential to be affected by the same practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?** The ADNS and/or designee will conduct random Medication Administration observations on each shift, twice a week for a minimum of 4 weeks to ensure proper technique and follow up is in place. Findings will be presented to QAA committee for review. Licensed Nurses will be educated on the Medication Administration guidelines to include ensuring residents receive medications as ordered and any pertinent documentation or interventions needed is completed related to an unusual observation.	

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	included, Peri Colace, Potassium, Naproxen, Prilosec, Norvasc, Zyprexia, Cymbalta, and Calcium Citrate. Resident # B's medications were viewed with LPN # 2 on 6/21/11 at 2:45 p.m. The Peri Colace was a small, red, football shaped gel capsule. The Norvasc and Zyprexia were both small white pills. The Director if Nursing (DoN) was interviewed on 6/21/11 at 3:30 p.m. during the daily exit meeting and further information was requested. The DoN was interviewed on 6/22/11 at 10:10 a.m. The DoN indicated she could not find a nursing note entry regarding the medications taken off the floor for Resident # B. She indicated she would have expected an incident report to be completed and the physician notified, but neither happened. She indicated the nurse could not be sure the resident had taken his own medications, someone else's medications, or the medications were taken at the right time. 3.1-35(a)		Licensed Nurses will be educated on timely reporting of an incident using the Quality Assurance and Performance Improvement Process guidelines inclusive of timely reporting of the incident, evaluation or assessment, physician and family notification. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** Six random Medication Administration observations will be completed weekly for at least four weeks with findings presented weekly to the QA&A. QA&A will review findings and determine need for further monitoring and/or education per the QA&A process. **By what date will systemic changes be completed?** July 15, 2011	

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F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to ensure the code status of 1 of 1 resident could be determined in order to provide the necessary services as designated by a resident's wishes for 1 of 1 resident in a sample of 9 (resident # A). Findings include: The closed clinical record of Resident # A was reviewed on 6/21/11 at 9:10 a.m. The record indicated the resident's diagnoses included, but were not limited to, Anemia, Aspiration Pneumonia, and Urinary Tract Infection. The physician's orders signed on 4/29/11 did not include a code status. The Advance Directive tab of the clinical record was empty. There was no mention on the resident's face sheet or in the clinical record regarding code status. The care plan dated 5/18/11 did not include any information regarding the resident's wishes for CPR	F0309	**F 309: D What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident A no longer resides at the facility. LPN involved is no longer employed at this facility. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions will be taken?** All residents have the potential to be affected by the same deficient practice. A facility audit will be completed to determine the code status of current residents to ensure their medical record information identifies the resident' s wishes. The findings of the audit will be reviewed by the QA&A committee for concerns and trends New admissions charts will be audited by the IDT within 48 hours of admission to ensure code status and resident wishes are identified. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?**QA&A committee will review the current system and adopt a standard identification system for	07/15/2011

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	[cardiopulmonary resuscitation] or no CPR. A nursing note dated 5/24/11 at 2:25 a.m. indicated, " Res (resident) RHC (respirations have ceased) @ (at) this time, no heart beat, no resp (respirations).". At 2:35 a.m. a note indicated the resident's family was contacted. The notes did not include any more of an assessment. The notes did not indicate CPR was preformed. LPN # 3 was interviewed on 6/20/11. The nurse indicated a resident's code status was found in the front of the clinical record. She indicated a green paper meant CPR was to be initiated and a red paper meant no CPR was to be initiated. LPN # 4 was interviewed on 6/20/11 at 6:55 a.m. The nurse indicated if she wanted to know a resident's code status, she would look under the Advance Directives tab in the clinical record. The nurse indicated another nurse would be available to assist with looking in a resident's chart to determine the code status and perform CPR. LPN # 5 was interviewed on 6/20/11 at 7:25 a.m. The nurse indicated if she found a resident with no pulse or respirations, she would call a "code" if she		maintaining the Advance Directive documentation in the medical record. Nursing, Social Services and Medical Records will be educated on the process of identification and filing of the patients Advance Directives. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur?** The risk identification tool for admissions will be used during department head/IDT meeting to determine the code status of new admissions. IDT will review the residents Advance Directive and supporting documentation at least quarterly. Findings will be reported to QA&A committee monthly.QA&A will review findings and determine need for further monitoring and/or education. **By what date will systemic changes be completed?** July 15, 2011	

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	was unsure about the status then look at the resident's advance directives in the chart for the resident's CPR wishes. The Director of Nursing (DoN) presented the facility's undated policy, " Do Not Resuscitate" on 6/21/11 at 10:45 a.m. The DoN indicated this policy included an inservice she presented to all of the nursing staff from June 8, 2011 through June 13, 2011. The policy indicated, " ... A physician must document in the patient's medical record : the DNR order...". The DoN was interviewed on 6/22/11 at 10:00 a.m. The DoN indicated CPR was not preformed when Resident # A was found with no pulse or respirations on 5/24/11 at 2:25 a.m. The DoN indicated according to facility policy, CPR should have been performed since the resident's wishes were not clearly defined in the clinical record. The DoN indicated the nurse was terminated because she did not reform CPR. 3.1-37(a)			